

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 2 - 0 4

2. STATE:

OKLAHOMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

01/01/02

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 442 and 42 CFR 447

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$-1,389,575b. FFY 2003 \$-1,858,025

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:

Deleting language regarding annual adjustment as a result of cost of living adjustment  
on Social Security benefits for Medicaid

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mike Fogarty

14. TITLE:

Chief Executive Officer

15. DATE SUBMITTED:

March 28, 2002

16. RETURN TO:

Oklahoma Health Care Authority

Attn: Billie Wright

4545 N. Lincoln, Suite 124

Oklahoma City, OK 73105

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

29 MARCH 2002

18. DATE APPROVED:

28 MAY 2002

## PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

01 JANUARY 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

CALVIN G. CLINE

22. TITLE:

ASSOCIATE REGIONAL ADMINISTRATOR  
DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

cc: Mike Fogarty  
Jim Hancock  
Billie Wright

**STATE PLAN AMENDMENT 02-04**

**Page number of the Plan  
Section or Attachment**

**Page number of the Superseded Plan  
Section or Attachment (if applicable)**

Attachment 4.19-D, Page 13  
Attachment 4.19-D, Page 26  
Attachment 4.19-D, Page 27  
Renumbering of pages starting with Page 27 thru 55  
Attachment 4.19-D, Page 42  
Attachment 4.19-D, Page 43.a  
Attachment 4.19-D, Page 56  
Attachment 4.19-D, Page 57

Same Page, revised 09/01/01, TN #01-17  
Same Page, Revised 09/01/01, TN #01-17  
Deleted  
  
Was page 43, Revised 01/01/02, TN #01-17  
Page deleted  
Page deleted  
Was page 57 – Now page 55

Also attached is a rate adjustment calculations worksheet.

4.19 -D p-13 Same 01-17  
4.19-D p 26-55 Same 01-17  
  
delete p 43a 01-17  
delete p 56 01-17  
delete p 57 01-17

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
FOR NURSING FACILITIES

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7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000 may not participate in the program and may not receive the enhanced rate adjustment of \$3.15. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program.

5. **SPECIALIZED SERVICES**

Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MR Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASSR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide standard private MR base rate described on Attachment 4.19-D page 41 and the statewide NF facility base rate in Section 3 E above.

6. **COSTS OF COMPLIANCE WITH OMNIBUS BUDGET RECONCILIATION ACT (OBRA) OF 1987**

All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

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A settlement will be made based on the variance in the amount of enhanced payments and the amount expended for wages and benefits paid for the specified staff. The settlement will be capped at \$3.15 per day.

Facility-specific target rates were determined for each provider. Fiscal year 1995 costs were used to set the rates. The target rates were calculated as follows:

1. The reported salaries and wages for the specified staff were summed for each facility (specified staff salaries).
2. An employee benefits ratio was determined by dividing total facility benefits by total facility salaries and wages.
3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.
4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.
5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.
6. An adjustment of \$3.15 per day was added to the trended base year costs to arrive at the target rate for each facility.
7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000 may not participate in the program and receive the enhanced rate adjustment of \$3.15. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program.

5. **COSTS OF COMPLIANCE WITH OMNIBUS BUDGET  
RECONCILIATION ACT (OBRA) OF 1987**

All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

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**STANDARD NURSING FACILITY SERVING VENTILATOR – DEPENDENT PATIENTS**

A statewide enhanced reimbursement rate shall be computed annually for nursing facilities (NFs) serving ventilator-dependent patients.

Definitions – Reimbursement is limited to the average standard rate paid to NFs serving adults plus an enhancement for ventilator patients. The enhanced payment is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. To qualify for the enhanced payment, a facility must (1) not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act, and (2) submit a treatment plan and most recent doctor's orders and/or hospital discharge summary to the Oklahoma Health Care Authority for prior authorization.

Rate Determination – The add-on rate is determined prospectively as follows:

1. The estimated cost of direct care personnel is calculated using ventilator care-related criteria developed by the State of Minnesota. The criteria identifies the tasks, caregiver time estimate (in minutes per day) and caregivers (RN, LPN, etc.) required to complete each element of care on a daily basis. (For blood gas tasks, a respiratory therapist was substituted for the RN).
2. Each care giver time estimate, within each task category, is added together to arrive at a total caregiver time estimate within each task category. The total caregiver time estimate is converted to hours per day. It is then multiplied by a projected hourly wage rate by class of caregiver to arrive at a cost per day for each caregiver within each task category. Each cost per day for each caregiver is added together to arrive at a total caregiver cost within each task category. Each total caregiver cost is added together to arrive at a total caregiver cost to complete all identified tasks. The projected hourly wage rates were derived from the most recently available NF cost reports.
3. A factor for fringe benefits is calculated by dividing total employee benefits by total salaries and wages. The total caregiver cost to complete all identified tasks is multiplied by the factor for fringe benefits to arrive at a fringe benefit cost. The fringe benefit cost is added back into the total caregiver cost to complete all identified tasks to arrive at an adjusted total caregiver cost. Total employee benefits and total salaries and wages was derived from the most recently available NF cost reports.

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4. Based on provider input, and other survey information, the estimated average hours of specialized care required by ventilator-dependent patients was 9 hours per day. Each caregiver time estimate within each task category was added together to arrive at a total time estimate to complete all identified tasks, which was 13.69 hours. The adjusted total caregiver cost is multiplied by the ratio of 9 hours divided by 13.69 hours to arrive at a specialized caregiver cost.
5. The total patient care cost from the most recently available NF cost reports was calculated. The total patient care costs include nursing personnel including nursing employee benefits, medical director including employee benefits, social and ancillary service personnel including employee benefits, contract nursing, other contract personnel, medical equipment, dietary, drugs and medical supplies.
6. The difference between 24 hours and the estimated average hours of specialized care required by ventilator-dependent patients (9 hours) is divided by 24 hours. It is then multiplied by the total patient care cost which is then added to the specialized caregiver cost to arrive at the total 24 hour cost of patient care.
7. Five percent of the total patient care cost will be allowed for the additional cost of medical supplies not reimbursed by Medicare. A \$4.00 per day adjustment will be allowed for nutritional therapy. Both additional costs are added back into the total 24 hour cost of patient care.
8. The difference between the total 24 hour cost of patient care (step 6) and the total patient care cost (step 5) is the add-on for ventilator patients.
9. The add-on for ventilator patients was inflated to the midpoint of the rate year using the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast.

Cost Report Requirements – Uniform cost reports will be required of each nursing facilities and the State will provide for periodic audits of such reports. Facilities will be required to submit a separate cost report for ventilator care.

Adjustments – The add-on rate will be inflated when standard NF rates are changed by the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast to the midpoint of the State Fiscal Year of the rate change.

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The add-on rate will be established prospectively according to the methods described above until a reimbursement rate can be derived from the cost reports which will reasonably reimburse the cost of an economic and efficient provider for ventilator patient care.

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**PUBLIC INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

Reimbursement for public ICF's/MR shall be based on each facility's reasonable and allowable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement.

**Service Fee** – In order to account for the cost of compliance with State law (House Bill 1114), which imposes a service fee on ICFs/MR, an interim allowance of \$20.49 per patient day will be made for FY '97.

The allowance calculation for the service fee will be calculated as follows: (1) establishing the Medicaid gross receipts from a base period, (2) multiplying the gross receipts by 6%, (3) dividing the product by the total Medicaid days during the base period to arrive at a daily amount.

Medicaid gross receipts were calculated by deducting those amounts recorded as patient liability. The number of Medicaid days was also reduced by the proportional number of days attributable to patient liability.

A settlement will be made based on the variance in service fees assessed and the amount of payments attributable to such fees received by the facility.

**STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF'S/MR)**

A statewide prospective rate of payment shall be determined annually for Oklahoma standard private intermediate care facilities for the mentally retarded. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate, Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

The rate is at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

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A. **COST ANALYSES**

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. **UNIFORM COST REPORTS**

Each Medicaid-participating ICF/MR facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

- a. **Reporting Period.** Each ICF/MR facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is required, covering each period of time the ICF/MR was in operation during the year.
- b. **Report Deadline.** The report must be filed by September 1 of each year. Extensions of not more than 30 days may be granted on a showing of just cause.
- c. **Accounting Principles.** The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.
- d. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the ICF/MR, by an officer of the company that manages the NF, and by the person who prepared the report.
- e. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any ICF/MR that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

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2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that ICF'S/MR incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the NF rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

3. **COMPUTATION OF THE STATEWIDE FACILITY BASE RATE**

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are rebased. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. **Primary Operating Costs**

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard ICF/MR facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services, which are described on page 4.
2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited

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costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjustment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.
4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital marketbasket index for the fourth calendar quarter of the previous fiscal year.

For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities in 3.B on pages 3 and 4. The allowance will be trended forward in the same manner as in 3.A.4 on page 3.

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C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to

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calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional \$.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of \$100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement.

This adjustment is calculated as follows:

1. Determine the direct care hours per day from the base year cost report data for all private facility types.
2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.

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3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.
5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is \$2.22.

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section 1-1925.2 of Title 63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

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3. HB 2019 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on 6% of the average gross revenue per patient day. An estimate of the Calendar 1999 surveys reporting this data was used to set the rate for the period beginning September 1, 2000.

This estimate and rate adjustment will be \$5.42 per day. For the period beginning October 1, 2000 the adjustment will be \$5.63. The estimate was determined by adding the primary operating cost, administrative services component, capital allowance component and "other" components for the rate period and dividing that total by .94 to get the total rate including the 6% fee. The total fee is the difference between the totals above. The OHCA was also directed to collect the assessment, assess penalties for late payment and deposit the assessments into a "Quality of Care Fund" and make payments from said fund for the purposes listed in the Bill.

The actual rate for the period beginning 09-01-00 will be determined from calendar 1999 surveys at a later date. When received, an adjusted rate will be established that reimburses the facilities for the estimated actual costs to be incurred during the rate period state fiscal year. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). For subsequent state fiscal years the per day assessment fee will be determined in advance from the totals of the monthly Quality of Care Reports, Section C, for the 6 month period from October 1 through March 31 of the prior fiscal year, annualizing those figures and determining the fee by dividing the total revenues by the total days and taking that result and multiplying by .06 (6%).

For the rate period beginning 09-01-01 the rate component was adjusted to \$6.05. This amount allows coverage of the provider fee currently in effect which was set as of 07-01-01 as defined in D.3 above. The rate period adjustment was determined by multiplying the actual fee increase by 365 days and dividing by the days left in the rate period (304, i.e. 12 month's fees spread over ten months) and adding to the previous fee (\$4.77).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
FOR NURSING FACILITIES

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4. For the rate period beginning October 1, 2000 an adjustment of \$3.33 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019. The minimum wage will be \$6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

The adjustment is determined as follows:

1. Determine the total cost per day for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
2. Determine the total cost per day for the Private NF's and the Private NF's Serving Aids patients.
3. Determine the percent difference between 1 and 2. If the difference is positive leave the result as positive for the factor below in 7.
4. Determine the total cost per hour for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
5. Determine the total cost per hour for the Private NF's and the Private NF's Serving Aids patients.
6. Determine the percent difference between 4 and 5. If the difference is positive then the result is negative for the factor below in 7.
7. Determine the salary cost add-on differential for M/R facilities by adding the results in 4 and 6.
8. Multiply this result by the add-on cost determined for Regular NF's on D.4, page 8.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

5. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data

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